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Regulated Industries Complaints Office
Department of Commerce and Consumer Affairs
State of Hawaii
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235 South Beretania Street, 9th Floor
Honolulu, Hawaii 96813
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Attorney for Petitioner

DEPT. OF COMMERCE AND CONSUMER AFFAIRS
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HEARINGS OFFICE

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BOARD OF DENTAL EXAMINERS
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII

In the Matter of the License to Practice Dentistry of	)	DEN 2002-11-L
TIMOTHY S. SMITH, DDS,	)	**SETTLEMENT AGREEMENT PRIOR TO FILING PETITION FOR DISCIPLINARY ACTION AND BOARD'S FINAL ORDER; EXHIBIT "1"**
Respondent.	)	

DEPT OF COMMERCE AND CONSUMER AFFAIRS
2004 JUN 23 P 3:03
HEARINGS OFFICE

SETTLEMENT AGREEMENT PRIOR TO FILING PETITION FOR DISCIPLINARY ACTION AND BOARD'S FINAL ORDER

This matter having been referred to the Regulated Industries Complaints Office (hereinafter "RICO") for prosecution for violation of Hawaii Revised Statutes (hereinafter "H.R.S.") Chapter 448, the parties TIMOTHY S. SMITH, DDS (hereinafter "Respondent") and the Department of Commerce and Consumer Affairs, through RICO enter into this Settlement Agreement on the terms and conditions set forth below:

A. UNCONTESTED FACTS

1. The Board of Medical Examiners of the State of Hawaii (hereinafter "Board") has jurisdiction over the subject matter herein and over the parties hereto pursuant to HRS Chapters 91, 92, 436B, and 448.

2. Respondent at all times relevant herein, was licensed to practice dentistry by the State of Hawaii, License Number DT 1036, said license being issued on March 2, 1978 and currently has an expiration date of December 31, 2006.

3. The last known address for Respondent is c/o M. Gayle Askern, Esq., Askern Law Firm of California, P.L.C., 1224 Tenth Street, #206, Coronado, California, 92118-3420.

4. RICO received information that on or about November 20, 2000, Respondent was subject to disciplinary action by the Dental Board of California (hereinafter "California Board") which Respondent failed to report to the Board of Dental Examiners of the State of Hawaii (hereinafter "Hawaii Board").

5. Respondent stipulates that on or about March 28, 1997, Respondent performed outpatient arthrocentesis on Kim Martin (hereinafter "Martin") who suffered from TMJ dysfunction.

6. Before beginning the arthrocentesis on Martin, Respondent administered .1 mg of Fentanyl, 5 mg of Decadron and 1 gm of Ancef to Martin. Respondent then began the procedure.

7. Approximately eleven (11) minutes into the surgery, Respondent administered an additional 5 mg of Fentanyl, between 2.5 and 5 mg of Versed, and 8 mg of Decadron to Martin.

8. Approximately six (6) minutes later, Respondent administered another 1 gm of Ancef to Martin.

9. Respondent then completed the Arthrocentesis procedure on the right side.

10. Respondent then noticed that Smith was wheezing and coughing. Martin's face also flushed with a patch of redness at the intravenous site.

11. Respondent administered Benadryl and a second dosage of Decadron intravenously and terminated the surgery procedure.

12. Martin began to regain consciousness and Respondent had Martin inhale from one of her inhalers for asthma.

13. Martin's condition worsened and Respondent declared an emergency situation and alerted his staff.

14. Respondent gave Martin a third dose of Epinephrine, however, Martin's oxygen saturation rates dropped into the 70's for a short period of time on a couple of occasions.

15. Martin's condition worsened and Respondent recognized a need to intubate Martin. Despite this recognition, Respondent did not intubate Martin nor did he say anything to the emergency personnel about the need to intubate Martin.

16. Paramedics arrived on scene and began to intubate Martin. Martin's pulse was lost and then restarted after Respondent began to administer CPR.

17. Paramedics transported Martin to a hospital.

18. Before leaving Respondent's office, paramedics requested and received a copy of Martin's original anesthesia log.

19. After Martin was transported to the hospital, Respondent made a misleading entry in the original anesthesia log by inserting a "2" in front of the second 5 mg dose of Versed thus reducing the amount administered from 5 mg to 2.5 mg and reducing the total amount of Versed administered to Martin from 10 mg to 7.5 mg.

20. In addition, Respondent created a second anesthesia log for Martin on which he entered false or misleading information regarding how the Versed was administered and Martin's blood pressure during the procedure.

21. Martin was pronounced "brain dead" on April 1, 1997.

22. On November 20, 2000, the California Board entered its Proposed Decision against Respondent. A true and correct copy of the California Board's decision is attached hereto as Exhibit "1."

23. Respondent stipulated to the following acts of negligence in his treatment of Martin before the California Board:

a. failure to conduct a timely and adequate review of the patient's medical history.

b. failure to conduct a timely and adequate review of the patient's medical history prior to deciding to perform surgery in his office rather than in a hospital.

c. failure to consult with patient's allergist prior to administering anesthesia and medication.

d. failure to obtain patient's informed consent to undergo conscious sedation and the risks of anesthesia prior to administering anesthesia and medication.

e. failure to insure that patient used the proper inhaler and that the inhaler had medication.

f. failure to conduct a physical examination of patient to determine the adequacy of her preoperative inhaler therapy.

g. failure to perform conscious sedation on the patient and instead used general anesthesia.

h. failure to insure appropriate staffing for the administration of general anesthesia.

i. failure to administer an appropriate /sufficient amount of Romazicon.

j. failure to administer any medication to reverse the effects of Fentanyl that had been administered.

k. failure to provide timely endotracheal intubation.

l. failure to keep adequate medical records.

m. administration of excessive doses of Versed Fentanyl.

n. altering a patient's medical records by creating false or misleading progress notes.

o. acts involving dishonesty, fraud or deceit with intent to substantially benefit himself.

24. RICO is prepared to file a Petition for Disciplinary Action against Respondent.

25. Respondent admits to the veracity of the allegations and that his acts constitute violations of the following statutes and/or regulations governing the conduct of dentists licensed by the State of Hawaii: HRS Sections 448-17(a)(12) (engaging in improper, unprofessional, or dishonorable conduct in the practice

of dentistry), 436B-19(13) and (15) (license revoked, suspended, or other disciplinary action taken by another state or federal agency and failing to inform the Hawaii Board of Dental Examiners of the action taken against the license).

26. Respondent has been apprised of the charges that would be brought against him should this matter proceed to an Administrative Hearing after the filing of a Petition for Disciplinary Action.

B. REPRESENTATIONS BY RESPONDENT

1. Respondent is fully aware that he has a right to be represented and advised by an attorney of his choosing, and is represented by M. Gayle Askren, Esq. in the present matter. Mr. Askren's address is 1224 Tenth Street, #206, Coronado, California 92118-3420.

2. Respondent has been advised of the allegations that would be brought against him should this matter proceed to an administrative hearing and understands that he is subject to penalties, including but not limited to revocation, suspension, probation or restriction of his dental license if the violations alleged are proven at a hearing. Respondent voluntarily waives his right to a hearing and agrees to a disposition of this case in accordance with the terms and conditions of this Settlement Agreement.

3. Respondent acknowledges that RICO has sufficient cause to file a Petition for Disciplinary action against his license to practice medicine.

4. Respondent admits the allegations contained for the Petition filed herein.

5. While Respondent admits to the allegations contained for the Petition filed herein, he submits that since the incident in question, he has taken numerous steps to prevent a repeat of this incident.

6. Respondent further submits that he has made changes which are above and beyond what has been required of him by the dental board of the State of California.

7. The parties desire to settle this matter in order to avoid further controversy and to avoid the time and expense of an administrative hearing;

8. Respondent enters into this Settlement Agreement freely and voluntarily and under no coercion or duress. Respondent is fully aware that in so doing, he is subject to disciplinary sanctions.

9. Respondent agrees that this Settlement Agreement is intended to resolve the issues raised in RICO's investigation in DEN 2002-11-L.

C. TERMS AND CONDITIONS OF SETTLEMENT AGREEMENT

1. **Voluntary surrender of license**. Respondent voluntarily agrees to a surrender of his license to practice dentistry in the State of Hawaii. Said surrender shall be effective immediately upon the approval date of this Settlement Agreement by the Board. Respondent shall turn in all indicia of

licensure to the Executive Officer of the Board within thirty (30) days from approval of this Settlement Agreement.

2. **Modification of Board's Final Order**. The parties stipulate that Respondent may Petition the Board for a modification of its order which will allow Respondent to apply for a dental license from the Board after two (2) years of the approval of this Settlement Agreement.

3. **Binding Effect**. The parties agree that the terms of this Settlement Agreement shall not become binding upon the parties unless and until it is approved by the Board.

4. **Failure to approve**. If the Board does not approve this Settlement Agreement and does not issue an order pursuant thereto, and requires instead that this matter be presented for administrative hearing before a hearings officer of the Department of Commerce and Consumer Affairs in accordance with HRS Section 91-9, Respondent agrees that neither he nor his attorney will raise any objection on any administrative or adjudicatory level on the basis that the Commission has become disqualified to consider the case before them because of its review and consideration of this Settlement Agreement.

5. **Ambiguities**. It is agreed that any ambiguity in this Settlement Agreement is to be read in the manner which most completely protects the interest of the consuming public.

6. **No representations**. Other than matters specifically stated in this Settlement Agreement, neither RICO nor anyone acting on its behalf has made any representation of fact, opinion or promise to Respondent to induce him to enter

into this Agreement, and Respondent is not relying upon any statements, representations, opinions or promises made by RICO or any of its agents, employees, representatives or attorneys concerning the nature, extent or duration of exposure to legal liability arising from the subject matter of this Agreement or concerning any other matter or thing.

7. **Final agreement**. This Settlement Agreement:

a) is a complete settlement of the rights, responsibilities, and liabilities of the parties hereto;

b) contains the entire agreement of the parties;

c) may only be modified, changed or amended by written instrument duly executed by all parties hereto.

DATED: San Diego, California, May 21, 2004 (date).

TIMOTHY S. SMITH
Respondent Pro Se

DATED: Honolulu, Hawaii, May 27, 2004 (date).

JOSEPH W. LEE
Attorney for Petitioner

APPROVED AS TO FORM:

M. GAYLE ASKERN
Attorney for Respondent

APPROVED AND SO ORDERED:

BOARD OF DENTAL EXAMINERS
State of Hawaii

STANWOOD H. KANNA, DDS - Chairperson

JUN 21 2004
DATE

GERALD ADACHI, DMD - Vice Chairperson

DAVID R. BREESE, DDS

GAYLE CHANG, RDH

WALLACE F. CHONG, JR., DDS

KAREN I. HU, DDS

DENNIS N. ISHIMOTO, DDS

STUART C. LAU

DEBORAH E. LICHOTA, RDH

ANN C. TERANISHI

RONALD YOUNG, DMD

JEFFREY K. MIYAZAWA, DDS

STATE OF CALIFORNIA)
)SS
COUNTY OF SAN DIEGO)

On this 21st day of May, 2004, before me personally appeared TIMOTHY S. SMITH, to me known to be the person described herein and who executed the foregoing instrument, and acknowledged that he executed the same as his free act and deed.

Jo S. Sand

NAME:
Notary Public, State of California

My commission expires: 5-20-2007

PROF & VOCATIONAL
LICENSING DIVISION

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DEPT OF COMMERCE
& CONSUMER AFFAIRS
STATE OF HAWAII

BEFORE THE
DENTAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against : TIMOTHY S. SMITH, D.D.S. 2878 Camino del Rio South, Ste. 210 San Diego, CA 92108 License DDS 23792 Respondent	AGS 1998-65 OAH L-2000060024

DECISION

The attached Proposed Decision by the Administrative Law Judge is hereby adopted by the DENTAL BOARD OF CALIFORNIA as its Decision in the above entitled matter.

This Decision shall become effective on 20 November 2000.

IT IS SO ORDERED this 20th day of October, 2000.

ROGER SIMONIAN, D.D.S.
PRESIDENT

EXHIBIT
"1"

BEFORE THE
BOARD OF DENTAL EXAMINERS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: TIMOTHY S. SMITH, D.D.S. 2878 Camino Del Rio South, Suite 210 San Diego, CA 92108 State Certificate No 23792 General Anesthesia Permit No. 0993 Respondent.	Case No. AGS 1998-65 OAH No. L1999080310

PROPOSED DECISION

Administrative Law Judge Joyce A. Wharton, State of California, Office of Administrative Hearings, heard this matter in San Diego, California on June 26, 27 and 28, 2000.

Thomas S. Lazar and Antoinette Cincotta, Deputy Attorneys General, represented the complainant.

Bruce E. Sulzner, Esq., of the firm Sulzner & Associates, represented respondent Timothy S. Smith, D.D.S., who was present.

The matter was submitted on June 28, 2000.

FACTUAL FINDINGS

1. On May 3, 1999 Georgetta Coleman, acting in her official capacity as the Executive Officer of the Board of Dental Examiners (hereinafter "complainant"), filed Accusation No. AGS 1998-65 against Timothy S. Smith, D.D.S. (hereinafter "respondent"). The Accusation was properly served on respondent and he filed a timely Notice of Defense.

2. On February 10, 2000 the parties entered a "Stipulation Regarding Administrative Hearing." Pursuant to the Stipulation the Accusation was amended to substitute the word "dose" for "5 mg" at page 15, lines 3-4, and the Second Cause for Discipline (Gross Negligence) was deleted.

The Stipulation contains the following pertinent language:

...respondent hereby knowingly, intelligently, freely and voluntarily admits the complete truth and accuracy of each and every charge and allegation contained in Accusation No. AGS 1998-65, as amended in paragraph 7 above.

...respondent hereby knowingly, intelligently, freely and voluntarily admits that he is guilty of each and every violation of the Dental Practice Act (Cal. Bus. & Prof. Code, §§ 1600, et seq.) described in Accusation No. AGS 1998-65, as amended...and, as a result, that he has thereby subjected his State Certificate No. 23792 and General Anesthesia Permit No. 993 to disciplinary action.

3. On July 1, 1973 the Board issued State Certificate No. 23792 to respondent, authorizing him to practice dentistry in California. The license has remained active and will expire on May 31, 2001 unless renewed. There is no history of prior discipline.

4. On August 20, 1985 the Board issued General Anesthesia Permit #752 to respondent. The permit expired May 31, 1986 and subsequently cancelled. On June 7, 1993 the Board issued General Anesthesia Permit #993 to respondent, authorizing him to administer general anesthesia in California. The permit has remained in effect and will expire May 31, 2001 unless renewed. There is no history of prior discipline.

5. Respondent received his dental degree from U.C.L.A. in 1973, graduating in the top 10% of his class. He joined the U.S. Navy in about 1973 and completed a general practice internship with the U.S. Naval Hospital in Oakland, followed by a three-year residency in Oral and Maxillofacial Surgery with the U.S. Naval Hospital in San Diego. While in the Navy respondent served as the Chief of the Dental and Oral and Maxillofacial Service in Okinawa, Japan, the department Head and Program Director of the Oral Surgery Service in the Naval Dental Clinic in San Diego, and the Assistant Director of the Oral and Maxillofacial Residency Training Program at the Naval Hospital in San Diego.

In addition to his California license, respondent obtained a dental license in Hawaii in 1977. The National Board of Dental Examiners has licensed him since 1973. He has been certified by the American Board of Oral and Maxillofacial Surgeons since 1983.

Respondent retired from the Navy after twenty years of service and entered private practice in 1993. Since that time respondent and Dr. Fred Hammond have practiced at and shared ownership of Mission Valley Oral and Maxillofacial Surgery in San Diego. Since about 1997 they have shared ownership of Mission Valley Outpatient, Inc., an outpatient surgical center.

6. Patient Kim Martin (hereinafter "Martin") was referred to Mission Valley Oral & Maxillofacial Surgery, Inc. by her physical therapist in January 1997. At that time Martin was 40 years old and suffering temporomandibular joint ("TMJ") dysfunction. Respondent first saw Martin on January 7 or 8, 1997 for an oral surgery consultation.

Martin filled out a one page health questionnaire on which she noted that she had shortness of breath and asthma, that she was then using asthma inhalers and taking Ventolin, Asthmacort, Relafan as a muscle relaxer and Robaxan, an anti-inflammatory. She noted that she was allergic to Penicillin and Tetracycline. Martin did not check either "yes" or "no" for the conditions "Recent illness (within one year)" and "Lung Disease". Respondent has no recollection of reviewing Martin's health questionnaire with her at the first visit, nor did he document such a review.

Respondent examined Martin and recommended that bilateral MRIs of her temporomandibular joints be obtained in order to accurately assess the position and dynamics of the joint discs.

7. On January 28, 1997 respondent reviewed the MRIs and noted that Martin had a right anteriorly displaced disc without reduction, left mild anterior displaced disc with reduction, with no other abnormality noted. Respondent noted in his progress notes, "Will schedule patient for review. Recommend left lysis and lavage."

Lysis and lavage means the same as "arthrocentesis", which is the puncture and aspiration of a joint. Needles are used for the procedure.

8. During an office visit on February 12, 1997 respondent reviewed the MRIs with Martin and discussed treatment options, including lysis and lavage. Respondent has no recollection of this meeting and discussion.

9. On February 13, 1997 respondent wrote a letter to Dr. Dan Hull, Martin's primary care physician. The purpose of the letter was to request authorization for the arthrocentesis procedure. After describing Martin's TMJ condition, the letter states in pertinent part:

> *Although she has displacement of both discs, she has only had significant pain in the left side. However, on her last appointment at my office (2-12-97) she stated that she was now having bilateral temporomandibular joint pain. ...*
>
> ...
>
> *I am requesting authorization for the following:*
>
> - *<u>Bilateral arthrocentesis</u> with injection of steroid to reduce intra-articular inflammation and pain. ...This can be done in an office setting and will not require hospitalization.*

10. On February 14, 1997 respondent's office faxed a pre-authorization to Dr. Hull. There was no evidence about whether Dr. Hull did or did not reply to respondent's February 13, 1997 letter or return the pre-authorization form.

11. On March 3, 1997 Martin was examined by the allergist, Dr. Robert Ziering. On about that date Dr. Ziering gave a report of his findings to Dr. Hull. The report noted that Martin was suffering from cold induced hives and itching upon getting out of the shower and from asthma "IgE –mediated (increase in wheezing with hay fever symptoms preceding)". The report stated that the asthma was especially bad in March, around dust, cut grass, car air conditioning, fog, Santa Ana winds, smoke, exercise, laughter, cats, dogs and horses. Dr. Ziering noted that Martin had previously had a problem with theophylline, generic for Theodur, which caused flushing, cramping and an emergency room visit. He prescribed new medications and a follow-up visit. There is no evidence that either Dr. Hull or Dr. Ziering sent this report to respondent.

Martin returned for her follow-up visit with Dr. Ziering on March 21, 1997. At that time Dr. Ziering noted her medication sensitivity and allergy to both Theodur and Erythromycin. "Theodur" is a bronchodilator which is indicated for the treatment of the symptoms and reversible airflow obstruction associated with chronic asthma and other chronic lung diseases such as emphysema and chronic bronchitis. There is no evidence that Dr. Ziering or Dr. Hull ever gave this information to respondent. There is no evidence of the new medications prescribed by Ziering.

12. On March 21, 1997 Dr. Hull faxed to respondent's office a copy of his notes regarding Martin's medical condition. The notes, in SOAP format, reflect Dr. Hull's examination of Martin on February 5, 1997. The pertinent parts follow:

S: *The patient was seen for follow-up regarding severe anaphylactic reaction. She states last weekend, while getting out of a shower in Texas she developed a severe shortness of breath and "huge hives" on her thighs and face. She had severe wheezing with great difficulty getting a breath. She gave herself an Epinephrine injection and called the paramedics. She was taken to the local hospital but states the symptoms started to improve significantly by the time she got there.*

She has a past history of allergies for many years but states the worst of these episodes with severe shortness of breath and hives have all occurred within the last two to three years. She was allergy tested many years ago and was positive for allergies to pine, cats, dogs, grass, and horses. She received a two-year course of allergy injections but had no benefit from this. The patient states she had eaten peanuts several hours prior to the reaction. Also, she was getting out of the shower when she had developed a few of her previous episodes of anaphylaxis.

...

A: *1. Recurrent anaphylactic reactions, unclear etiology*
2. Worsening blurred vision of left eye.
3. TMJ dysfunction.

P: *Referral to Dr. Ziering for allergy consultation. Await MRI scan results of the TMJ. ....*

13. "Anaphylaxis" is defined in Dorland's Illustrated Medical Dictionary, 27th Edition, as follows:

> *A manifestation of immediate hypersensitivity (q.v.) in which exposure of a sensitized individual to a specific antigen or hapten results in life-threatening respiratory distress, usually followed by vascular collapse and shock and accompanied by urticaria, pruritus, and angioedema. Common agents causing anaphylaxis include Hymenoptgera venom, pollen extracts, certain foods, horse and rabbit sera, heterologous enzymes and homones, and certain drugs, such as penicillin and lidocaine.*

14. Dr. Hull's SOAP note was placed in Martin's chart, but respondent does not remember seeing it. He "theorizes" that the normal office procedure for handling incoming mail about a patient was not followed and his staff filed the note without giving it to him to read.

15. Respondent scheduled Martin's arthrocentesis procedure for March 28, 1997. Prior to this date he knew, or should have known, that she suffered shortness of breath and asthma, used asthma inhalers and was taking other medications. Prior to March 28, 1997 respondent did not request any medical records from Dr. Hull regarding Martin's asthma and allergy conditions.

16. On the morning of March 28, 1997 Martin, accompanied by her boyfriend Danny, went to respondent's office to undergo the arthrocentesis. At approximately 11:00 a.m. they went into the operating room where they discussed Martin's medical condition with respondent and a surgical assistant. Respondent reviewed with Martin her condition, symptoms and her history of asthma and shortness of breath. Respondent does not recall discussing her medical history before this time. Danny told respondent that Martin had three or five previous anaphylactic reactions, including one where Martin had to give herself an Epinephrine injection with her Epi-pen (a self-dosing Epinephrine injection pen). Danny told respondent Martin was allergic to everything, "a 12 on a scale of 1 to 10", that her allergies included evergreens, cold, cats, dogs and grass, and that she was being seen by an

allergist and Dr. Hull. Martin told respondent she was allergic to amoxicillin and tetracycline, but not penicillin. Respondent decided to speak to Dr. Hull before starting the procedure.

At no time prior to the scheduled surgery did respondent request medical records from Dr. Hull's office regarding Martin's allergies and asthma condition. And, apparently, at no time prior to the surgery did respondent review his own patient file thoroughly enough to find Dr. Hull's notes that were faxed to him on March 21, 1997. Respondent did not try to contact Dr. Ziering before the surgery.

17. Respondent called Dr. Hull and spoke with him by phone. At this time, and based on his treatment of Martin since 1995, Dr. Hull knew that her asthma became more severe in March, that she was allergic to Theodur and Doxycycline, had suffered a severe anaphylactic reaction in February, 1997, and was currently seeing an allergist. Respondent and Dr. Hull discussed Martin's history of anaphylactic reactions.

Respondent did not ask Dr. Hull any questions about Dr. Hull's knowledge of any medications to which Martin might be allergic. He did not discuss with Dr. Hull Martin's allergies to amoxicillin and tetracycline.

Respondent advised Dr. Hull of some of the medications, including the anesthetic agents, he intended to use during the arthrocentesis. Dr. Hull recalled that respondent mentioned Fentanyl, but he was unsure about Versed, and did not recall any mention of Decadron. In prior testimony Dr. Hull testified that respondent did not discuss the use of Ancef. The evidence presented at the hearing, including respondent's stipulations, was not sufficiently clear and convincing to establish exactly which medications were mentioned in the conversation between respondent and Dr. Hull.

Dr. Hull told respondent that he "did not see any problem with those anesthetics" that respondent said he was going to use.

Dr. Hull recommended that respondent pre-medicate Martin with Benadryl and Solu-Medrol if he thought she had any symptoms that would be alleviated by doing so.

18. There is no evidence that Dr. Hull, as the primary care physician fully aware of Martin's medical history, said anything to respondent to dissuade him from going forward with the outpatient arthrocentesis. There is no evidence that Dr. Hull felt he did not have sufficient information before him to engage in the pre-surgical consulting conversation. There is no evidence that Dr. Hull informed respondent about Dr. Ziering's report. There is no evidence that Dr. Hull expressed any concern about an anaphylactic reaction occurring during the arthrocentesis procedure.

19. Respondent informed Martin and Danny that he decided to go forward with the elective arthrocentesis. He asked Danny to bring Martin's inhalers and her Epi-pen to the operating room. An emergency medical kit was brought into the room. There is no evidence of its contents.

Respondent decided not to pre-medicate Martin with Benedryl or Solu-Medrol. Respondent explained that these medications are normally given when an allergic reaction is underway. Martin had no allergic symptoms on the day of surgery and told respondent she felt better than she had in months.

Respondent instructed Martin to take two puffs from her inhaler. Respondent did not know what medication was in the inhaler and he neither inquired nor confirmed the contents and amount.

As the procedure was about to begin, Danny left the room.

20. Martin's arthrocentesis was to be performed under conscious sedation. Business and Professions Code §1647.1(a) defines "conscious sedation":

> *...a minimally depressed level of consciousness produced by a pharmacologic or nonpharmacologic method, or a combination thereof, that retains the patient's ability to maintain independently and continuously an airway, and respond appropriately to physical stimulation and verbal command.*

21. At no time prior to the start of Martin's scheduled arthrocentesis procedure did respondent discuss with her the risks of anesthesia in connection with asthma or anaphylaxis. At no time prior to the start of the procedure did respondent obtain Martin's informed consent to undergo conscious sedation.

On March 28, 1997 Martin did sign a "Statement of Consent for Oral Surgery" that included information about local anesthesia and general anesthesia. Respondent has no recollection of reviewing the statement with Martin, nor does he remember if he discussed the differences between local or general anesthesia and conscious sedation.

22. It was approximately noon on March 28. 1997 when respondent started to administer the various medications to place Martin under conscious sedation and prepare her for the arthrocentesis. Respondent administered the following drugs through a catheter that had been placed in Martin's arm:

Fentanyl – a narcotic analgesic. (*Dorland's Pocket Medical Dictionary*, 24th Ed.)

Versed – a short-acting central nervous system depressant. According to the 1997 Physician's Desk Reference (PDR), intravenous Versed has been associated with respiratory depression and respiratory arrest, especially when used for conscious sedation. *"In some cases, where this was not recognized promptly and treated effectively, death or hypoxic encephalopathy has resulted."* (1997 PDR, at p. 2324, col. 2.)

Decadron – a steroid that is an anti-inflammatory agent. It is helpful in reducing postoperative inflammation and swelling.

Ancef – an antibiotic. The 1997 PDR describes the adverse reactions: *"Serious and occasional fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more likely to occur in individuals with ...a history of sensitivity to multiple allergens. ...Before initiating therapy with Ancef, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins or other allergens. ...Serious anaphylactic reactions require immediate emergency treatment with epinephrine. Oxygen, intravenous steroids and airway management, including intubation, should also be administered as indicated."* (1997 PDR, at p. 2633, col. 1.)

23. Before beginning the arthrocentesis on the right side, respondent administered .1 mg of Fentanyl, 5 mg of Versed, 8 mg of Decadron and 1 gm of Ancef. He then began the surgical procedure. Approximately eleven minutes into the procedure, respondent administered .05 mg Fentanyl, another dose of Versed (the amount, between 2.5 to 5 mg is in dispute) and another 8 mg of Decadron. Approximately six minutes later respondent administered another 1 gm of Ancef.

24. Respondent completed the right side arthrocentesis. Through a precordial stethoscope he heard Martin wheezing and coughing. At the same time he saw her face flush and his assistant advised him there was a patch of redness at the IV site, which respondent observed.

Respondent administered Benadryl and a second dose of Decadron intravenously. He then decided to terminate the procedure. Respondent administered 1 mL Epinephrine, 250 mg Aminophylline drip, and 1 cc of Romazicon.

Romazicon is a drug used to reverse the effects of benzodiazepines such as Versed. The 1997 PDR describes the dosage to reverse the sedative effects of benzodiazepines:

For reversal of the sedative effects of benzodiazepines administered for conscious sedation or general anesthesia, the recommended initial dose of romazicon is 0.2 mg (2 mL) administered intravenously over 15 seconds. If the desired level of consciousness is not obtained after waiting an additional 45 seconds, a further dose

of 0.2 mg (2 mL) can be injected and repeated at 60-second intervals where necessary (up to a maximum of 4 additional times) to a maximum total dose of 1 mg (10 mL). The dose should be individualized based on the patient's response, with most patients responding to doses of 0.6 to 1 mg. ...

25. Martin, who had been in a supine position, began to regain consciousness and respondent brought her to a sitting position. She was wheezing and had a dry cough. Respondent had Martin use one of her inhalers. She appeared worse, with increased wheezing and labored breathing. Respondent gave Martin one of the office inhalers to use and blew oxygen across her face with an oxygen mask. Martin did not improve. Respondent declared the situation an emergency and alerted the staff.

Martin said "I know what is happening, I need some Epinephrine." Respondent replied, "We have already given it to you, wait for it to work."

Martin became semi-conscious, making respiratory efforts but appearing to have bronchial constriction. Respondent gave the order to call 911.

26. Respondent's partner, Dr. Fred Hammond, entered the room and began to manage Martin's airway. She appeared to be worsening and continued to have increased labored breathing. Respondent told Dr. Hammond they had a functional laryngoscope and a good ET tube and could intubate Martine if they needed to. Respondent and Dr. Hammond decided not to intubate her at that time.

27. Respondent gave Martin a third dose of Epinephrine. Martin's oxygen saturation rates dropped into the 70s for a couple periods of 20 seconds or so. Firefighters arrived and one of them took over management of Martin's airway. Dr. Hammond returned to his own patient. Respondent turned his attention away from the patient in order to set the Aminophylline drip rate. When he turned back to the patient he saw that her oxygen saturation rates continued to drop, she developed bradycardia and her face became a gray. Respondent suddenly realized they were losing her. He recognized a need to intubate Martin but made no effort to do so, nor did he say anything to the firefighters about the need to intubate.

28. Paramedics arrived and immediately intubated Martin. Martin lost a pulse and respondent started CPR. The pulse was restored and the paramedics transported Martin to Sharp Memorial Hospital. On arrival she was comatose.

Martin failed to improve neurologically and, on April 1, 1997, she was confirmed to be brain dead.

29. On April 3, 1997 a Certificate of Death was issued for Martin. The Certificate listed the immediate cause of death as "Hypoxic encephalopathy" due to "Severe anaphylaxis during temporomandibular joint surgery". "Bronchial asthma" was listed as a significant condition contributing to death, but not related to the immediate cause. There was no evidence to establish the cause of the anaphylaxis.

30. Pursuant to his stipulation, respondent admitted the following acts of negligence in his care and treatment of patient Martin:

A. Failure to conduct a timely and adequate review of the patient's medical history, including her history of asthma, reactive airway disease, allergies, including allergies to medications, and anaphylaxis.

B. Failure to conduct a timely and adequate review of the patient's medical history prior to deciding that her surgery could be done in an office setting and would not require hospitalization.

C. Failure to consult with the patient's allergist prior to administering anesthesia and other medications to her on March 28,1997.

D. Failure to obtain the patient's informed consent to undergo conscious sedation and, in light of her medical history, failure to discuss the risks of anesthesia in connection with asthma or anaphylaxis with the patient prior to administering anesthesia and other medications on March 28, 1997.

E. Failure to insure the patient used the appropriate inhaler preoperatively and failure to insure that the inhaler used had medication in it. (There was no evidence either by stipulation or testimony at hearing that the inhaler used was not appropriate or that it was empty.)

F. Failure to perform a physical examination through auscultation of the patient in order to determine the adequacy of her preoperative inhaler therapy.

G. Failure to perform conscious sedation on the patient and, instead, performing general anesthesia.

H. Failure to insure appropriate staffing for the administration of general anesthesia to the patient.

I. Failure to administer an appropriate and/or sufficient amount of Romazicon to the patient.

J. Failure to administer any medication to reverse the effects of the Fentanyl that had been administered to the patient.

K. Failure to perform timely endotracheal intubation of the patient.

L. Failure to maintain adequate medical records for the patient.

31. Pursuant to his stipulation, respondent admitted that in his treatment of patient Martin on March 27, 1997, he administered excessive doses of Versed and Fentanyl, separately and in combination, for conscious sedation and, as a result, of those excessive doses, failed to maintain a margin of safety wide enough to render unintended loss of consciousness unlikely. Respondent stipulated that this conduct subjects his State Certificate No. 23792 and General Anesthesia Permit No. 0993 to discipline under Business and Professions Code sections 1670 and 1647.9, as defined by section 1647.1(b) of the code.

32. Shortly before the paramedics transported Martin to the hospital, one of them requested and obtained a copy of the original anesthesia log that had been filled in during the arthocentesis procedure and the recovery efforts (hereinafter "unaltered log"). Respondent was not aware of this.

Sometime after Martin had been taken from the office, respondent made a misleading entry on the original anesthesia log. He inserted "2." In front of the second 5 mg dose of Versed, thus reducing the second dose from 5 mg to 2.5 mg. and at the same time reducing the total amount of Versed allegedly administered to the patient from 10 mg to 7.5 mg.

At some time after Martin had been taken from the office and before 1:30 p.m. on March 28, 1997, respondent created a second anesthesia log (hereinafter "Log #2"), which he placed into the patient's file. Log #2 contained the following entries that were false or misleading:

- An entry showing that three doses of Versed at 2.5 mg each had been given to Martin between 0 minutes and approximately 10 minutes into the procedure. Respondent does not specifically remember how he administered the Versed to Martin or how it was titrated. Nor does respondent remember at what point in the procedure he administered the third dose.

- A series of false and misleading entries reflecting blood pressure from 5 minutes to approximately 30 minutes. Respondent admitted the numbers do not accurately record the patient's blood pressure. He explained that he did not know the specific blood pressure numbers but intended to show "trends" in Martin's blood pressure during the procedure and resuscitation.

Pursuant to his stipulation, respondent admitted that, by his conduct described in this Finding, he altered patient Martin's records with intent to deceive and thereby has subjected

his dental certificate and general anesthesia permit to disciplinary action under section 1670, as defined by section 1680, subdivision (s).

33. At some time after Martin had been taken from the office and during the day of March 27, 1997, respondent wrote progress notes in Martin's chart that contained the following entries that were false or misleading:

- Respondent wrote that Martin "denied any anaphylactic shock to meds". This is false because respondent never asked Martin if she had any anaphylactic shock to medications. He only asked her if she had any allergic reactions to the medications listed on her health history questionnaire, *i.e.*, penicillin and tetracycline.

- Respondent wrote that he administered 5 mg of Versed to Martin. The unaltered anesthesia log reflects 10 mg administered to Martin. The altered log and Log #2 reflect a total of 7.5 mg.

- Respondent wrote that after 911 had been called Martin's blood pressure was 180/100. Respondent testified he believes he took these numbers from Log #2, which contains the blood pressure numbers fabricated by him to reflect the trend of her blood pressure.

Pursuant to his stipulation, respondent admitted that, by his conduct described in this Finding, he altered patient Martin's records with intent to deceive and thereby subjected his dental certificate and general anesthesia permit to discipline under section 1670, as defined by section 1680, subdivision (s).

34. Pursuant to his stipulation, respondent admitted that by altering Martin's medical record and by creating false and/or misleading progress notes as described in Factual Findings 32 and 33, he has committed acts involving dishonesty, fraud or deceit with the intent to substantially benefit himself or another. Respondent stipulated that he has thereby subjected his dental certificate and general anesthesia permit to discipline under section 1670, as defined by section 1680, subdivision (x), and section 480, subdivision (a)(2).

35. Pursuant to his stipulation, respondent admitted that he failed to maintain records pertaining to Martin's treatment as required by Title 16, California Code of Regulations, section 1043.3(b) and, thereby, has subjected his dental certificate and general anesthesia permit to discipline under section 1670 and 1647.9, as defined by section 1647.6.

Respondent admitted that he failed to maintain adequate medical history and physical evaluation records for Martin.

Respondent admitted that he failed to maintain conscious sedation records, including multiple blood pressure and pulse readings, drugs, amounts administered and time administered, length of the procedure, any complications of anesthesia or sedation and a statement of the patient's condition at the time of discharge.

36. Pursuant to their stipulation, the parties agree that the reasonable cost of investigation and enforcement of this case is the sum of $30,000.00, and that, pursuant to section 125.3, respondent is obligated to pay that sum to the Dental Board of California.

Aggravation

37. Complainant offered evidence in aggravation[1] to consider in determining the discipline to impose. Complainant contends that during the civil wrongful death malpractice suit against respondent, he repeatedly lied under oath about whether he made a significant alteration to original anesthesia log.

At this administrative hearing respondent unhesitatingly testified on direct examination that he altered the original anesthesia log by inserting "2." in front of entry for the second dose of Versed, thus changing the 5 mg dose to a 2.5 mg dose. On direct examination respondent did not say he had no memory of doing this. Respondent also admitted this conduct by his stipulation entered on February 10, 2000. In contrast to his stipulation and hearing testimony, respondent gave the following testimony under oath in the case number 717299 before the Superior Court of California, County of San Diego:

Deposition, July 15, 1998, pages 206-208

(Regarding respondent's discussion with Dr. Hammond)
Q. Did you discuss the fact that you were going to prepare a second chart?
A. You mean a second anesthesia log?
Q. ...Yes.
A. Yes.
Q. Tell me what you remember regarding those discussions.
A. We looked at the anesthesia log that was there, and we both agreed that it was inaccurate, and we both agreed that it wasn't right to try to change the original log. So the only thing that made any sense to us was let's make up a second log that's as accurate as we can and make sure it's identified as a log from recollection, not from the actual log.
Q. So at that time you and Dr. Hammond agreed that no changes should be made to the original log?

[1] Any circumstance attending the commission of an act of unprofessional conduct that increases its guilt or enormity or adds to its injurious consequences may be a factor in aggravation. (See *Black's Law Dictionary*, Revised 4th Edition.)

A. I don't know if I specifically asked him that. But I knew that myself, that I shouldn't be doing that.b
Q. So from the time of the surgery to the present, no changes have been made to the original log?
A. One.
Q. What was that change?
A. The – I wrote down there Benadryl when I first took a look at that log and I realized there wasn't any Benadryl. And I wrote that down. And then I looked at the log and I said, "This is way out of whack. All the numbers are wrong." And I said, "There is no point even looking at that log."
...
Q. When did you make that addition?
A. Well, within a few minutes of the time that she had left the office and I was sitting down with the chart.
Q. At the time you wrote "Benadryl 100", did you make any other changes to that chart?
A. None.
Q. And from the time you made that Benadryl 100 mark, have you ever made any other changes to this chart?
A. No, I have not.

Deposition, July 20, 1998, pages 339-340

(Regarding changes to the original anesthesia log)
Q. ...You don't believe that any changes were made to [the original log] *after Kim's surgery and emergency?*
Mr. Sulzner: *Well, you mean other than what he has already testified to about the Benadryl that he put on there?*
Ms. Asher: *Okay*
Q. And that would be the one addition that you made?
A. That's the one that I know of.
Q. To the best of your knowledge, no one else made any other changes to this log after Kim Martin's surgery and emergency?
A. That's correct.

Deposition, December 8, 1998[2], pages 398-399.

Q. ...Do you have any information as to who wrote the 2. in front of the second 5 on the line next to the Versed?
A. No.
Q. Do you believe you did it?
A. I believe it is possible.
Q. But you don't have any recollection?

[2] The unaltered copy of the anesthesia log was discovered after July 20, 1998 during the paramedic's deposition.

A. No.

Trial Testimony, March 1, 1999, pages 153-154.

Q. As we heard earlier, it was your testimony that the only change that you ever made to this log was adding Benadryl 100, right?
A. That's the only change that I remember making, that's correct.
Q. When I asked you in your deposition if you had made any other changes to this log, you told me none, right?
A. Well, I don't remember making any more, no.

Confronted at the hearing with this prior inconsistent testimony, respondent explained that, despite his admission to the fact of altering the Versed entry on the original anesthesia log, he still does not remember doing it, but believes he did it.

Respondent has repeatedly made either false or equivocal statements under oath about a fact crucial to the interest of his patient and her family. He failed to explain why he did this.

38. In mitigation[3] of his conduct in the treatment of Martin, respondent explained his hesitancy to intubate, his custom and practice for completing the anesthesia log and accounting for the drugs, and his reason for creating the false medical record.

Respondent testified that there is no doubt in his mind he did not do what he should have done to timely intubate Martin. He assumed the firefighters were managing her airway and directed his attention to setting the dose for the aminophylline drip. When the EKG beep indicated Martin's heart rate was drastically slow, he turned to her, realized they were losing her and "froze". Respondent's expert witness, Dr. Wedel, testified that a practitioner who does not intubate frequently loses the skill and the self-confidence to do it in an emergency. Dr. Wedel testified that it is a common reaction of one who does not intubate frequently to hesitate and miss the window of opportunity.

At the time of Martin's surgery it was respondent's custom and practice to have all the drugs that might be used during surgery predrawn into color-coded syringes. For example, the Versed syringe contained 5 mg, the Fentanyl syringe contained .1 mg and so on. When respondent called for the Versed syringe, the assistant noted the full amount of the syringe on the anesthesia log at the appropriate minute mark. Respondent contends it was his custom and practice not to administer the full 5 mg all at once, but to titrate it at 2.5 mg for each dose. At the end of the surgery respondent and/or his assistant would look at the syringes, determine the amount remaining, if any, and then make notations on the anesthesia

[3] Mitigating circumstances do not constitute a justification or excuse of the unprofessional conduct but, in a sense of fairness and mercy, they may be considered as extenuating or reducing the degree of culpability. (See *Black's Law Dictionary*, Revised 4th Edition.)

log to reflect the total amount actually administered. However, the log would not reflect the amount or time of each separate dose was given. Apparently respondent saw nothing unusual or inadequate about this practice.

Respondent was following his customary practice with the anesthesia log during Martin's surgery. However, when the emergency started no one took charge of making entries in the log. After Martin was taken to the hospital, respondent looked at the log and realized it was " a mess". He changed the Versed dose to "2.5" and added the Benedryl then realized it would be better to make a second record as accurately as possible. He discussed this with his partner, prepared Log #2 and put both anesthesia logs in the file. In light of all the inaccurate or false information in Log #2, the only mitigating conduct is that respondent did not try to hide or dispose of the original log.

There are few if any truly mitigating circumstances in this case. It is true that Dr. Hull did not share some crucial information with respondent, but respondent's custom and practice of waiting until the time of surgery to discuss the patient's risk factors and to personally contact the primary care physician is inexcusable. It is true that respondent "froze" when faced with the critical emergency but, in his dual role as surgeon and anesthesiologist performing outpatient surgery, that was not an option. He has no justification for his failure to adequately staff his surgery and to be properly prepared to handle emergencies in the outpatient setting. It is understandable that respondent cannot remember the details of each arthrocentesis he performs because they are such routine and repetitive procedures. However, this made more important the accurate recording of the entire procedure on each patient.

Respondent purports to be a well-trained and experienced oral surgeon who completed a six-month anesthesia rotation during his residency. By the time Martin became his patient he had practiced oral surgery, including administration of anesthesia for more than twenty years. Yet his practices for evaluating patient risk, and for monitoring and recording vital signs and drug administration during a surgical procedure, were abysmal. It is of great concern that respondent could reach that point in has career and remain so clueless.

Rehabilitation

39. Respondent has accrued 421 hours of CME credit since March 27, 1997. It is notable that the day before Martin's surgery respondent received 42.5 hours of credit for attendance at the annual meetings of the American College of Oral and Maxillofacial Surgeons and the American Academy of Osseointegration. Relevant courses include the following:

- Understanding Risks in Medically Compromised Patients (7 hours), June 6, 1999;
- Anesthesia Management of the Pediatric Patient (3 hours) January 22, 2000;
- Loma Linda University 21st Annual Dental Anesthesia Update (16 hours), February 13-14, 2000;

- General Anesthesia Training at St. Joseph Hospital, New Jersey, with Intubation (20 hours), February 16-17, 2000;
- Loma Linda Univ. Record Keeping, Documentation and Chart Review (7 hours), March 20, 2000;
- California Society of Dental Anesthesiologists In Office Anesthesia Review (8 hours), April 25, 2000; and
- Advanced Cardiac Life Support (16 hours) June 24-25, 2000.

40. At the time of Martin's surgery respondent's office protocols and practices were appalling in their inadequacy. His "custom and practice" for recording the medications administered to the patient was a recipe for disaster. He was completely unprepared to handle the emergency situation that arose during Martin's surgery. Respondent has made significant improvements in his office protocols to remedy the prior deficiencies.

The testimony of Mark K. Wedel, M.D., was especially credible and persuasive. Dr. Wedel is Board Certified in Internal Medicine and Critical Care and is well qualified to offer an unbiased opinion. Not only does Dr. Wedel serve as a consultant for the Board, he was retained as an expert witness to testify on behalf of Martin's survivors in their wrongful death malpractice suit against respondent. He made a thorough review of all of the pertinent medical records and deposition transcripts before testifying at trial that respondent's treatment of Martin fell below the standard of care. He was critical of respondent's conduct in taking the medical history, depth of inquiry before deciding to perform surgery, management of the emergency and documentation of events. For the purpose of this administrative proceeding respondent asked Dr. Wedel to review his current office practice with a focus on the processes he found lacking during respondent's treatment of Martin. Dr. Wedel made a checklist of criteria to evaluate respondent's current practice and spent the afternoon of June 2, 2000 at the office reviewing the procedures and medical records.

It is Dr. Wedel's opinion that respondent "has made significant changes such that he has created an environment where the maximum margin of safety exists." Dr. Wedel found that the new systems are exemplary and the disciplines respondent has placed on himself exceed the standard of care. Respondent has created new forms to assist in the accurate recording and sharing of the patient's medical history. He obtains information from the primary care physician and assesses the risks before the patient is scheduled for surgery. The assessment of the patient's risks is documented in the chart. Respondent does not perform any surgery unless two days prior the patient's primary care physician provides a written statement clearing the patient for the procedure. Respondent informs the primary physician in writing of each drug that might be administered to the patient. Consent forms have been redrafted to include extensive information about the various surgical procedures and attendant risks. Respondent has installed a state of the art system in the surgery room for monitoring and recording vital signs in order to reduce the chance of human error. Respondent uses two assistants for every surgical procedure, even if only conscious sedation

is used. One assistant records the medication as given by respondent along with a verbal crosscheck.

Dr. Wedel believes respondent has taken the appropriate steps to address his hesitancy to intubate the patient. He has recently taken a clinical course to restore his proficiency in performing intubation and, when an anesthesiologist is present for the surgery, respondent will perform the intubation under his or her supervision if allowed. Dr. Wedel noted that respondent took a course in medical record keeping and is now using a standard method of accounting for the medications used in surgery. Dr. Wedel concluded that he would trust respondent to perform surgery and administer anesthesia to him.

41. Robert Adams, M.D., is a Board Certified anesthesiologist who serves as a senior examiner for the American Board of Anesthesiology. Dr. Adams spent the morning of June 8, 2000 in respondent's office reviewing the office systems, the operating room procedures, the emergency cart, and observing respondent's clinical technique for administering anesthesia. Dr. Adams was impressed with the response to the acknowledged deficiencies in respondent's practice that became manifest in the Martin case. It is Dr. Adam's opinion that respondent's current practice regarding the administration of anesthesia is completely safe, is designed to provide the maximum margin of safety, and exceeds the standard of care. Respondent is using the same operating room monitors as used in hospitals. Respondent now states the amount and time for each drug as it is administered and the assistant records it. Dr. Adams feels that respondent has responded admirably and his practice is completely satisfactory for administering anesthesia.

42. Respondent does seem sincere in acknowledging that he did not ask Martin or Dr. Hull the right questions in order to get the complete information about her condition. He has revised his health questionnaire to include more information and contends that he asks more probing questions of the patient. All incoming mail from other physicians is attached to the outside of the chart and will not be filed until respondent has initialed it. Any significant medical problem is noted as a medical alert on the patient's computer record so that the computer file cannot be used to schedule the patient for surgery until the alert is read. Respondent now uses a more extensive evaluation process before recommending a surgical procedure. He has trained his staff to use the new procedures and forms.

43. By letter dated March 27, 2000 complainant notified respondent that he had satisfactorily completed the general anesthesia on-site inspection and evaluation required by Section 1646.4 of the Business and Professions Code.

Appropriate Discipline

44. Complainant argued that because this case involves a patient's death, the Board would accept nothing less than revocation of respondent's dental license and anesthesia permit. Despite the tragic result for Martin and her family, complainant has stipulated that this is not a case of incompetence or gross negligence. No statute or regulation requires revocation when a patient dies after multiple negligent acts during treatment. Obviously respondent's unprofessional conduct was serious and contributory, but there was no evidence of exactly what caused Martin's adverse reaction or what specific event or events caused her death. Respondent was not the only medical professional contributing to the tragedy. All circumstances must be considered and the Board must still exercise its discretion based on the evidence.

Respondent's technical skills as an oral and maxillofacial surgeon are not challenged. He has a good reputation among peers who consider him an excellent surgeon who will take on the most difficult cases and is regularly asked to consult. However, doubts remain about respondent's knowledge and skill as an anesthesiologist. According to Dr. Wedel, the use of conscious sedation is "a very artful business" and its risk depends on the skills and talent of the caregiver.

Respondent's revised forms and office protocols address only half of the Board's concerns. The system is only as good as the medical professional who is in charge of it. At the heart of an effective and safe system is the integrity of the caregiver who must not only consistently implement the safeguards of the system but also pay close attention to each patient's individual medical issues. Respondent's fate is bound by his unequivocal admission that he created false medical records with intent to deceive in a case involving a medical emergency and ultimate fatality. At the time respondent altered the original anesthesia log and created the second log with false information, he had to know that, even if Martin survived, his medical record of her surgery would be subject to scrutiny.

Respondent's post-procedure alteration and fabrication of Martin's medical records and his untrue testimony under oath during the malpractice litigation raise a serious question about whether respondent is worthy of the public trust essential for the administration of anesthesia. It is not just trust that respondent will be honest in performing his medical duties but also trust that in a difficult or emergency situation he will be able to maintain his composure and carry out his professional duties in the best interests of his patient. It was not respondent's natural inclination to face up to either his professional obligations or his obvious errors and omissions. Certainly it is difficult and, perhaps, traumatic, for a health care professional to accept that complications during a low risk procedure caused a patient's death. But it has taken respondent two years to acknowledge that his conduct as an anesthesiologist in the treatment of Martin did not meet the standard of care. It is in the public interest that respondent's General Anesthesia Permit be revoked. Respondent's skills as an oral and maxillofacial surgeon will be best used in the presence of a licensed anesthesiologist.

With regard to respondent's dental license, his admitted creation of false medical records with intent to deceive and the evidence in aggravation demand revocation. However, several factors support a stayed order of revocation. Respondent has practice oral surgery for approximately 24 years without prior discipline and he has been practicing for the past three years without incident. His technical skills as a surgeon are not questioned. He has acknowledged his responsibility for Martin's death and he has made some extraordinary efforts to remedy procedural deficiencies and to enhance his professional knowledge. Respondent seems to have learned the importance of maintaining complete and accurate records and the pitfalls of creating false records. Giving respondent the benefit of the doubt about his untrue or inaccurate statements under oath, it may be that the trauma of Martin's event and the fact that he was acting according to custom caused him to forget that he altered the Versed dose on the original anesthesia log. A probationary license will protect respondent's interest in his professional license and safeguard the public.

A probationary period of five years is significant and sufficient. The Board's guidelines recommend a minimum 30-day suspension and complainant requests at least 90 days. A 30-day suspension is appropriate and will allow respondent time to plan for a practice without his general anesthesia permit. A longer suspension becomes disruptive of patient care and is thus more harmful than beneficial to the public. Respondent's time is better spent in practice with his new procedures and some general oversight.

LEGAL CONCLUSIONS

1. Cause was established to subject respondent's dental certificate and general anesthesia permit to discipline pursuant to Business and Professions Code section 1670 for repeated acts of negligence in his profession. Factual Findings 1 through 35 inclusive support this conclusion.

2. Cause was established to subject respondent's dental certificate and general anesthesia permit to discipline pursuant to Business and Professions Code sections 1670 and 1647.9 for unprofessional conduct, by reason of respondent's violation of section 1647.1(b), which provides as follows:

> *The drugs and techniques used in conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely.*

Factual Findings 1 through 31 inclusive support this conclusion.

3. Cause was established to subject respondent's dental certificate and general anesthesia permit to discipline pursuant to Business and Professions Code sections 1670 for unprofessional conduct, by reason of respondent's violation of section 1680, subdivision (s),

which provides that unprofessional conduct includes the alteration of a patient's record with intent to deceive. Factual Findings 1 through 34 inclusive support this conclusion.

4. Cause was established to subject respondent's dental certificate and general anesthesia permit to discipline pursuant to Business and Professions Code sections 1670 for unprofessional conduct, by reason of respondent's violation of section 1680, subdivision (x) and section 480, subdivision (a)(2).

Section 1680, subdivision (x), defines unprofessional conduct as any action or conduct which would have warranted the denial of the license. Section 480, subdivision (a)(2) authorizes denial of a license for any act of the licensee involving dishonesty, fraud or deceit with the intent to substantially benefit himself or substantially injure another.

Factual Findings 1 through 34 inclusive support this conclusion.

5. Cause was established to subject respondent's dental certificate and general anesthesia permit to discipline pursuant to Business and Professions Code sections 1670 and 1647.9 for unprofessional conduct, by reason of respondent's violation of section 1647.6 and Title 16, California Code of Regulations, section 1043.3(b).

Section 1647.6 provides:

A physical evaluation and medical history shall be taken before administration of conscious sedation. Any dentist holding a permit shall maintain records of the physical evaluation, medical history, and conscious sedation procedures used as required by board regulations.

Section 1043(b) of the regulations requires the following records be maintained:

(1) Adequate medical history and physical evaluation records.
(2) General Anesthesia and/or conscious sedation records, which shall include multiple blood pressure and pulse readings, drugs, amounts administered and time administered, length of the procedure, any complications of anesthesia or sedation and a statement of the patient's condition at the time of discharge.

Factual Findings 1 through 35 inclusive support this conclusion.

6. Cause was established pursuant to Business and Professions Code section 125.3 to direct respondent to pay the reasonable costs of investigation and enforcement of this case. Pursuant to the parties' stipulation the sum of $30,000.00 represents the reasonable costs.

Factual Findings 1 through 36 inclusive support this conclusion.

7. Cause was established to revoke respondent's General Anesthesia Permit.

Factual Findings 1 through 44 inclusive and Legal Conclusions 1 through 5 inclusive support this conclusion.

8. Cause was established to revoke respondent's Dental Certificate and to stay the order of revocation on probationary terms and conditions.

Factual Findings 1 through 44 inclusive and Legal Conclusions 1 through 5 inclusive support this conclusion.

ORDER

General Anesthesia Permit No. 993 issued to Timothy S. Smith, D.D.S. is revoked.

Dental Certificate No. 23792 issued to Timothy S. Smith, D.D.S., is revoked; however, the order of revocation is stayed for a period of five years on the following terms and conditions:

1. Suspension - Commencing from the effective date of this decision, respondent shall be suspended from the practice of dentistry for a period of 30 days. Respondent shall not mislead patients regarding the reasons for suspension from practicing dentistry. During the suspension respondent shall not practice dentistry directly or indirectly, including the supervision of dental auxiliaries, nor shall respondent receive or have set aside for future receipt, any new monies derived from the practice of dentistry as defined by the provisions of Business and Professions Code section 1625, which includes managing or conducting as manager, proprietor, conductor, lessor, or otherwise, a place where dental operations are performed.

   If respondent operates his own office as a solo practice or as a one person professional corporation, said office is to be closed except for administrative purposes (making future appointments when suspension is over, opening mail, referring patients, accepting payments on account, and general office administration); and respondent shall not lease the dental office nor make any monetary gain from the practice earned during the period of time that the office is closed.

2. Supervision – Within 60 days of the effective date of this decision, respondent shall submit to the Board, for its prior approval, the name and qualifications of one or more proposed supervisors and a plan for each such supervision by which respondent's practice would be supervised.

The plan of supervision shall be general and not require the physical presence of the supervising dentist during the time dental and/or surgical procedures are performed but does require an occasional random check of the patient's chart, anesthesia log and work performed on the patient. Additionally, the supervision shall have full and random access to all patient records of respondent.

Each proposed supervisor shall be a California licensed dentist and oral/maxillofacial surgeon, or practice in such other area as the Board deems appropriate, who shall submit written reports to the Board on a quarterly basis verifying that supervision has taken place as required and include an evaluation of respondent's performance. It shall be respondent's responsibility to assure that the required reports are filed in a timely manner.

The supervisor shall be independent, with no prior business or professional relationship with respondent and the supervisor shall not be in a familial relationship with or be an employee, partner or associate of respondent. If the supervisor terminates or is otherwise no longer available, respondent shall find a new supervisor, subject to the Board's approval, within thirty days. If a new supervisor is not found within 30 days, respondent shall not practice until the Board approves a supervisor. All costs of the supervision shall be borne by the respondent.

This condition shall apply for the first two years of probation; however, the condition shall not be terminated unless the supervising dentist reports to the Board that in his or her opinion general supervision is no longer needed.

3. Ethics Course – Within 30 days of the effective date of this decision, respondent shall submit for prior Board approval a course in ethics which will be completed within the first year of probation. Units obtained for an approved course in ethics shall not be used for continuing education units required for renewal of licensure.

4. Obey All Laws - Respondent shall comply with all conditions of probation and obey federal, state and local laws and all rules and regulations governing the practice of dentistry in California, and remain in full compliance with any court ordered criminal probation, payments and other requirements.

5. Quarterly Declarations - Respondent shall submit quarterly declarations under penalty of perjury on the Board's Quarterly Report of Compliance forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

6. Probation Surveillance - Respondent shall comply with the Board's probation surveillance program.

7. Interviews - Respondent shall appear in person for interviews with a Board representative upon request at various intervals and with reasonable notice.

8. Change of Address - Respondent shall inform the Board in Writing within 15 days of any change of place of practice or place of residence. Respondent shall at all times keep the Board informed of his or her address of business and residence which shall both serve as addresses of record. Under no circumstances shall a post office box serve as an address of record. Respondent shall also immediately inform the Board, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 days.

9. Cost Recovery – Respondent is hereby ordered to reimburse the Board the amount of $30,000 within 90 days from the effective date of this decision for its investigative and prosecutorial costs up to the date of the hearing. Failure to reimburse the Board's cost of its investigation and prosecution shall constitute a violation of the probationary order unless the Board or its Executive officer agrees in writing to payment by an installment plan because of financial hardship. However, full payment must be received no later than one year prior to the scheduled termination of probation.

10. License Surrender – Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily surrender his license to the Board. The Board reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.

11. Absence from State/Practice – In the event respondent should leave California to reside or practice outside the State, respondent must provide written notification to the Board of the dates of departure and return. Periods of residence or practice outside of California will not apply to the reduction of the probationary period. In the event respondent ceases to actively practice dentistry in California, respondent must provide written notification of that fact to the Board. The period when the respondent is not practicing will not apply tot eh reduction of the probationary period. Absence from the state or absence from the practice shall not relieve the respondent from fulfilling the condition of probation requiring reimbursement of costs or restitution to patients or on behalf of patients.

12. Continuance of Probationary Term/Completion of Probation – If respondent violates the terms of this probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may set aside the stay order and impose the revocation or suspension of the respondent's license. If, during the period of probation, an accusation and/or a petition to revoke probation have been filed against respondent's license, the probationary period shall automatically be extended and shall not expire until the accusation and/or the petition to revoke probation has been acted upon by the Board. Upon successful completion of probation, respondent's license will be fully restored.

Dated: September 14, 2000

JOYCE A. WHARTON
Administrative Law Judge
Office of Administrative Hearings

ASKREN LAW FIRM OF CALIFORNIA, P.L.C.

Ask Askren.

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June 16, 2004

Joseph W. Lee, Staff Attorney
Hawaii Dept. of Commerce and Consumer Affairs
Regulated Industries Complaints Office
235 South Beretania Street, Ninth Floor
Honolulu, Hawaii 96813

Re: Timothy S. Smith, D.D.S., No. DEN2002-11-L

Dear Mr. Lee:

Thank you for your telephone call concerning a certain typographical correction required to the first page of the document entitled, SETTLEMENT AGREEMENT PRIOR TO FILING PETITION, etc. of this matter.

On behalf of Dr. Smith, I hereby express my written concurrence with that certain change to the above agreement which is described as follows: At paragraph A.1., following the paragraph number, the words "The Board of Dental Examiners" shall be substituted for and in place of "The Board of Medical Examiners." This amendment is necessary accurately to address the public agency exercising jurisdiction in this matter.

Please call if there are any additional concerns. I apologize for not noticing this error during my review of the agreement. Dr. Smith reaffirms his agreement with the terms of the settlement and solicits the concurrence therein by the Board of Dental Examiners.

Sincerely,

M. Gayle Askren, Attorney at Law
ASKREN LAW FIRM OF CALIFORNIA P.L.C.

cc: client
MGA/rbp

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1. The Board of Dental Examiners of the State of Hawaii (hereinafter "Board") has jurisdiction over the subject matter herein and over the parties hereto pursuant to HRS Chapters 91, 92, 436B, and 448.

2. Respondent at all times relevant herein, was licensed to practice dentistry by the State of Hawaii, License Number DT 1036, said license being issued on March 2, 1978 and currently has an expiration date of December 31, 2006.

3. The last known address for Respondent is c/o M. Gayle Askern, Esq., Askern Law Firm of California, P.L.C., 1224 Tenth Street, #206, Coronado, California, 92118-3420.